



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

SILVIO BRUNA, DC

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-17-0511-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

OCTOBER 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim for Designated Doctor referred testing has been reduced/cut inappropriately based on the MAR for the CPT Codes billed according to DWC rule 133 and 134."

Amount in Dispute: \$400.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a fee schedule reduction...Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2016	CPT Code 97750-FC(X16)	\$400.80	\$400.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.225, effective July 7, 2016, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1003-In response to your appeal of our previous re-evaluation, no significantly additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.

Issues

Is the requestor entitled to additional reimbursement for the functional capacity evaluation rendered on July 21, 2016?

Findings

28 Texas Administrative Code §134.225 states “The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier “FC.” FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required.”

CPT code 97750 is defined as “Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.” CPT code 97750 requires direct one-on-one patient contact.

A review of the submitted Functional Capacity Evaluation report indicates “Total Test Time: 4.0 Hours.”

28 Texas Administrative Code §134.225 states that FCEs shall be reimbursed in accordance with §134.203(c)(1).

28 Texas Administrative Code §134.203(c)(1) states “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83.”

28 Texas Administrative Code §134.203(c)(2) states “The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

The Division conversion factor for 2013 is \$58.62.

The Medicare conversion factor for 2016 is 35.8043.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78550 which is located in Harlingen, Texas; therefore, the Medicare locality is “Rest of Texas.”

The Medicare participating amount for CPT code 97750 is \$31.85.

Using the above formula, the MAR is \$52.15 per unit. The requestor billed for 16 units; therefore, \$52.15 X 16 \$834.40. The respondent paid \$404.32. The difference between MAR and amount paid is \$430.08. The requestor is seeking a lesser amount of \$400.80; this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$400.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$400.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	11/22/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.